Crisis Intervention Services
Appendices

Page #

Appendix 1
Sample HCFA 1500 Claim
for Crisis Intervention Services

APPROVED OMB-0938-0008

← CARRIER →

HEALTH INSURANCE CLAIM FORM

| | PICA | | | | | | | PICA | |

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
(Medicare #)	P (Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)	**1234567890**	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY SEX
MM DD YY M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY
Anytown   STATE **WI**

8. PATIENT STATUS
Single [ ] Married [ ] Other [ ]

CITY   STATE

ZIP CODE **55555**   **TELEPHONE** (Include Area Code) **(XXX) XXX-XXXX**

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE   **TELEPHONE (INCLUDE AREA CODE)** ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State) [ ] YES [ ] NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT MM DD YY ◄ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 06CR   3.
2. 12CR   4.

22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE						B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
From MM	DD	YY	To MM	DD	YY										
02	02	97				0	1	W9553	1	XX XX	2.0				24681012
02	15	97				0	1	W9557	1	XX XX	2.0				87654321
02	16	97	02	17	97	0	1	W9558	1	XXX XX	4.0				12345678

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized **MM/DD/YY**
SIGNED   DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555   86754321
PIN#   GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)   **PLEASE PRINT OR TYPE**   FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 2
HCFA 1500 Claim Form Completion Instructions
for Crisis Intervention Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers must always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. Do not indicate any other numbers unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Do not enter anything in this element if no health insurance is indicated under "Other Coverage" on the recipient's identification card.

If the recipient's Medicaid identification card indicates private health insurance under "Other Coverage," you must attempt to bill the private health insurance. If you receive payment from the private insurer, indicate the following code in the first box of element 9:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.

Leave this element blank if the other insurer denies payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number
Leave this element blank.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - I.D. Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter a presenting problem code here. Refer to Appendix 4 of this handbook for a list of presenting problem codes. List the main presenting problem first. The presenting problem description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization (not required)

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines.

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.

- The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 6 of this handbook for a list of allowable place of service codes for crisis intervention services.

Element 24c - Type of Service Code

Enter the type of service code "1" here.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for a list of allowable procedure codes for crisis intervention services.

Element 24e - Diagnosis Code

Enter the number (1, 2, 3, or 4) which corresponds to the appropriate presenting problem code in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Refer to Appendix 6 for appropriate billing units.

Element 24h - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG (not required)

Element 24j - COB (not required)

Element 24k - Reserved for Local Use

Enter the eight-digit provider number of the performing provider *for each procedure*. This is different from the billing provider number used in element 33. Enter your non-billing performing provider number here, if you are a county or tribal agency that is also a performing provider.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.

Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid by health insurance in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

> *Note:* This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number. This will always be the county or tribal agency's Medicaid billing number.

Appendix 3
Procedure Codes for Crisis Intervention Services

Procedure Codes

Code	Description
Code	*Description*
W9551	Initial assessment and planning - MD
W9552	Initial assessment and planning - PhD
W9553	Initial assessment and planning - MS/RN
W9554	Initial assessment and planning - Other
W9555	Crisis linkage and follow-up - MD
W9556	Crisis linkage and follow-up - PhD
W9557	Crisis linkage and follow-up - MS/RN
W9558	Crisis linkage and follow-up - Other
W9559	Crisis stabilization - MD
W9560	Crisis stabilization - PhD
W9561	Crisis stabilization - MS/RN
W9562	Crisis stabilization - Other

For information on staff qualifications for crisis intervention billing levels, refer to Appendix 8 of this handbook.

Appendix 4
Presenting Problem Codes for Crisis Intervention Services

Presenting Problem Codes

The presenting problem is the reason the recipient needs crisis intervention services. You must enter a presenting problem code (listed below) in element 21 of the HCFA 1500 claim form. You may enter up to three codes, but enter the primary presenting problem first. These codes correspond to the codes used in the Human Services Reporting System (HSRS) mental health module.

Code	Description
01CR	Marital/Family problem
02CR	Social/Interpersonal (other than family problem)
03CR	Problems coping with daily roles and activities (includes job, housework, daily grooming, financial management, etc.)
04CR	Medical/Somatic
05CR	Depressed mood and/or anxious
06CR	Attempt, threat, or danger of suicide
07CR	Alcohol
08CR	Drugs
09CR	Involvement with criminal justice system
10CR	Eating disorder
11CR	Disturbed thoughts
12CR	Abuse/Assault/Rape victim
13CR	Runaway behavior
14CR	Emergency detention

Appendix 5
Matching Fund Requirements

Wisconsin Medicaid funds are a combination of state and federal funds. In order for the state to collect the approximately 60 percent federal share, Wisconsin Medicaid has to secure approximately 40 percent as the state share. For Medicaid crisis intervention, existing state and local funding will constitute this state match. This could be county tax levy or any state GPR aids allocated to county agencies administering crisis intervention services to eligible recipients. This has two implications:

- First, when an agency submits a bill to the fiscal agent for the actual allowable hours of the crisis intervention services, the fiscal agent pays the federal share to the county agency, subject to reimbursement limits set by the Department of Health and Family Services (DHFS).

- Second, Medicaid-certified crisis intervention agencies must have sufficient state or local funding to serve as the non-federal share of crisis intervention reimbursement and must maintain an audit trail to document expenditures for eligible recipients.

There are two limitations on funds allowable for matching funds:

1. Federal monies may not be used to match the federal share of Medicaid dollars, unless the federal funds are authorized by the federal government for this purpose.

2. Local funds already being used to match other federal funds may not be used as a match for crisis intervention. Examples of this include:

    - The same local funds may not be claimed as a match for Community Support Program (CSP) services and crisis intervention.

    - The same local funds may not be claimed as a match for maternal/child health block grants and crisis intervention.

Bona fide donations may be used as matching funds. Bona fide donations are defined in 42 CFR 433.54.

Providers are encouraged to contact Wisconsin Medicaid at the address below if providers are considering using funds other than county tax levy or community aids allocated to your agency as the local funds.

Write to:
Mental Health Policy Analyst
Bureau of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Appendix 6
Rounding Guidelines and Allowable Place of Service Codes

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s).

Billing in One-Tenth Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

Place of Service Codes

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Appendix 7
For Mental Health Crisis Intervention Billing Providers:
To Request a Non-Billing Performing Provider Number

If you are a county or tribal government agency that is certified as the billing provider in your county (the agency that provides the matching funds) and you are seeking HFS 34, Subchapter 3 certification to perform crisis intervention services, you must complete the following steps to notify the Medicaid fiscal agent, EDS:

1. Complete this form and send it to the fiscal agent *at the same time* you request an HFS 34, Subchapter 3 certification application from the Division of Supportive Living (DSL).

2. Send a copy of the HFS 34, Subchapter3 certificate to the fiscal agent within 30 days of DSL approval. This will allow the fiscal agent to assign you the earliest possible effective date for a non-billing performing provider number. If the fiscal agent receives the copy of the HFS 34, Subchapter 3 certificate more than 30 days after DSL approval, the effective date of the non-billing performing provider number will be the date the fiscal agent receives the copy of your HFS 34, Subchapter 3 certificate.

3. Include your new non-billing performing provider number on claims for services your agency performs on and after the effective date assigned to your non-billing performing provider number.

If you obtain HFS 34, Subchapter 3 certification for separate locations, use this form to request a separate non-billing performing provider number for *each* location.

Please photocopy this page so you can retain the original in your handbook.

Mental Health Crisis Intervention Billing Provider Name:_____

_____

Address: _____
                            Street   **City**   **Zip**
(The physical location of your agency performing these services; this must match the address used on the HFS 34 application.)

IRS Number:_____ **Billing Provider # :**_____

Medicaid Contact Person: _____ **Phone:** _____
(You may want someone listed other than the individual listed on your billing provider file.)

Signature: _____ **Date:** _____

Please send this completed form to the following address:

> **Provider Maintenance**
> **EDS**
> **6406 Bridge Rd.**
> **Madison, WI 53784-0006**

Appendix 8
Staff Qualifications for Mental Health
Crisis Intervention Billing Levels

Wisconsin Medicaid defines four billing levels for crisis intervention staff. The following crosswalk identifies at which level crisis intervention agencies must bill for staff services. Staff qualifications are based on program staff definitions in HFS 34.21 (3) (b) 1-19, Wis. Admin. Code.

Crosswalk Between Medicaid Billing Levels and Staff Specialties	
Medicaid Billing Level	**Staff Specialty**
MD	Psychiatrists Psychiatric residents
Ph.D.	Psychologists
MS/RN	Certified independent clinical social workers Certified social workers Master's-level clinicians Occupational therapists Post-master's-level clinician interns Professional counselors and marriage and family therapists Psychiatric nurses Psychology residents Registered nurses
Other	Certified occupational therapy assistants Clinical students Licensed practical nurses Mental health technicians Other qualified mental health professionals Physician assistants Specialists in specific areas of therapeutic assistance

These groupings are for the purpose of determining billing levels only. The clinical responsibility and authority of staff at various levels is dictated by HFS 34, Wis. Admin. Code, and Wisconsin Medicaid policies as outlined in the crisis intervention handbook.

Example: Although you bill psychiatric resident services at the same level as a psychiatrist's services, the resident may not approve services by signing off on the response plan or crisis plan. According to HFS 34.23 (5) (b) and (7) (d), Wis. Admin. Code, and Medicaid policies only a psychiatrist or licensed psychologist who is listed or eligible to be listed in the national register of healthcare providers in psychology may approve services.

Example: Although you bill registered nurse services at the same level as master's-level social worker services, the registered nurse does not have the authority to supervise staff that is given to providers meeting the qualifications of HFS 34.21 (3) (b) 1. to 8., Wis. Admin. Code.